

State Employee Benefits Committee
Tatnall Building, Room 112
Dover, Delaware 19904

The State Employee Benefits Committee met June 4, 2018. The following people were in attendance:

Committee Members:

Mike Jackson, OMB, Chair
Saundra Johnson, DHR
Mike Morton, CGO
Evelyn Nestlerode, Designee of Chief Justice, Administrator of Courts
Tanner Polce, Designee of Lt. Governor
Ken Simpler, OST
Stuart Snyder, Designee for DOI
Jeff Taschner, DSEA
Kara Walker, DHSS

Guests:

Brenda Lakeman, Director, Statewide Benefits Office (SBO), DHR
Faith Rentz, Deputy Director, SBO, DHR
Mary Thuresson, SBO, DHR
Andrew Kerber, DOJ
Myrna M. Abbott, DRSPA
Jennifer Bredemeier, Univ of DE
Victoria Brennan, CGO
Rebecca Byrd, The Byrd Group
Steven Costantino, DHSS
David Craik, Pension Office
Cherie Dodge-Biron, DHR
Cindy Diaz, OMB, PHRST

Guests (continued):

Jacqueline B. Faulcon, DRSPA
Kim Hawkins, City of Dover
Geoff Heath, Christiana Care
Leighann Hinkle, SBO, DHR
Mary Kate McLaughlin, Drinker Biddle
Regina Mitchell, OMB
Myrna M. Abbott, DRSPA
Karol Powers-Case, DRSPA
Paula Roy, DCSN
Christine Schiltz, PG&S
George Schreppler, DCSN
Jim Testerman, DSEA-R

Julie Caynor, Aetna
Carrie Schiavo, Delta Dental
Judy Grant, Health Advocate
Lisa Mantegna, Highmark
Jennifer Mossman, Highmark
Walt Mateja, IBM Watson Health
Robert Rodriguez, IBM Watson Health
Kevin Fyock, Willis Towers Watson
Chris Giovannello, Willis Towers Watson
Jaclyn Iglesias, Willis Towers Watson
Rebecca Warnken, Willis Towers Watson

Introductions/Sign In

Director Jackson called the meeting to order at 1:00 p.m. Introductions were made.

Approval of Minutes - handout

The Director entertained a motion to approve the minutes from the April 23rd SEBC meeting. Secretary Johnson made the motion and the Secretary Walker seconded the motion. The motion carried unanimously.

Director's Report – Brenda Lakeman, Statewide Benefits Office (SBO)

Open Enrollment (OE) Engagement Stats: School Districts, including Charter Schools and Higher-Ed show 79.6% OE completion, up from 50% last year. Agencies finished with 84.7% completed, an increase from 60.1% in 2017. Overall, OE completion was 81.7%, up from 54.1% last year. The "What's New" video shows 53.9% participation rate, up from 46.8% in 2017. SBO received a lot of positive feedback from this OE and plans to distribute a post OE survey to employees focused on communications and engagement. The completed migration is not yet available so any changes to enrollment in accumulating the data from various systems will be available at the June 25th meeting. Director Jackson suggested a message from SEBC to employees on their positive engagement for this OE be distributed.

Legislative Updates: SBO is watching four Bills closely that could impact benefits:

- SB 151: Contraceptive Coverage with the changes to GHIP coverage being coverage for Plan B emergency drugs without a prescription and 12 month supply of contraception at one time. We are working on impacts with ESI and expect impact to be minimal.
- HB 386: Coverage for treatment with IVIG for Pediatric Autoimmune Disease Neuropsychiatric Disorders associated with strep infections with an impact of \$100K.

- HB 323: Settlement funds to revert to General Fund which would impact the health fund in terms of monies received from TPAs due to subrogation. We are suggesting an amendment to this Bill as it would affect SBO and ICO with an impact of \$1.5M.
- SB 199: Primary Care – require PCP rates be paid no less than Medicare rates; working through fiscal impact now.

ACA penalty 2015 - Received Letter 226J from IRS on May 11th for penalty assessed for full time employees (ACA definition) who were not offered healthcare or not offered affordable and minimum healthcare coverage. \$87,620 assessed for 91 employees ranging from 1 to 12 months per employee. SBO has reviewed and data is correct with one exception, therefore we will pay \$86,580 from the health fund by June 11th to avoid penalties/interest and then bill each organization.

Delta Dental Assignment of Benefits (AOB)- As a follow up to the last meeting for non-network dentists, SBO is working with Delta Dental on a contract amendment to conduct a pilot to put AOB in place effective September 1, 2018 with the requirement that the out of network (OON) dentists review and have the member sign an Attestation form which asserts their status as OON and specify the portion the member must pay in advance (the difference between billed charges and dental insurance coverage). This form must be filed with the claim form to Delta in order to receive direct payment. Delta will closely track any change to the network where in-network dentists leave the network and if the network changes within a 5% decrease, we would revert to no payment to OON physicians.

Financials

Fund Equity – (F&E) April 2018 – handout - Willis Towers Watson (WTW)

April fund shows a spike in claims with \$69.3M compared to the budget of \$64.6M, largely offset by additional revenues into the fund driven by a coverage gap discount payment for the EGWP program of \$3.8M. Generated income of \$400K brings the total equity fund balance to \$147.5M. The Director noted the variance remains as the first three quarters with \$64M over and above the reserves and expects a deeper dive to understand the occurrence this year compared to prior years in order to set up a framework for decision making for FY2020.

Group Health Migration and Utilization Analysis – handout - Willis Towers Watson (WTW)

This analysis provides a deeper view into the cost and utilization from data for all of FY17 through FY18 Quarter 2 (YTD). There was \$29.9M net income generated by the Fund over the period of July 2017 through December 2017. Highmark medical claims were \$2.7M over budget, Aetna medical claims were \$23.8M below budget. New care management programs (CCMU and AIM) are likely contributing to favorable experience for both vendors, yet a longer time period is needed, at least one year. Incurred claims per member per month remained flat in FY18 Q1-Q2 compared to full year in FY17. Highmark PPO plan participants have higher relative risk scores (174) than Aetna HMO (149) and CDH (119) plan participants. The Highmark PPO plan experienced a 3.8% increase in Emergency Room visits from FY17, while all other plans decreased or remained flat. Net medical payments PMPM decreased 11% for members moving from the Highmark HMO to the Aetna HMO (driven by a decrease in utilization), while payments generally increased for other GHIP cohorts. Overall GHIP population risk is 62% above benchmark average. The overall utilization trend was reviewed. Member movement at the start of FY18 from the Highmark HMO and CDHP plans were examined. Relative risk decreased in the Aetna HMO plan and the Aetna CDHP plan and increased slightly in the Highmark First State Basic plan. Relative risk remained stable in the Highmark PPO plan. The overall trend for medical payments on a per member per month (PMPM) basis increased slightly (by less than 1%) from \$402 to \$406 across all plans. Net payments PMPM for inpatient services decreased by 8% from \$132 to \$121, while net payment PMPM for outpatient services increased by 5% from \$269 to \$282.

Utilization changes between Highmark HMO and CDHP members and the Aetna HMO membership were reviewed as shown in percentages; SEBC requested WTW to provide same data shown in dollars. PCP utilization decreased in the first half of FY18, but did move upward in the Highmark FSB plan. The top 15 specialties by overall volume in FY17 shows utilization increased. The rate of utilization of urgent care increased among all four plans, while the change in the rate of visits to emergency rooms for similar conditions varied. Despite a spike in hospital utilization for the Highmark FSB plan and a smaller increase in hospital utilization in the Aetna CDHP plan, overall, utilization of high-tech imaging services declined at both hospitals and freestanding facilities.

WTW would like to see another quarter of data to view how the migration smooths out. SBO will try to map out the average migration from plan to plan for multiple years to provide additional data for FY19 outlook to give committee a

better understanding of utilization. At the next meeting, WTW will provide a view of CCMU and AIM specific engagement metrics as positives to the plan to continue.

Group Health FY19 Planning – Health Savings Account (HAS) Plan - handout - Willis Towers Watson (WTW)

A continued look at a Health Savings Account plan and if desired, how to potentially implement this plan going forward. Plan design requirements for the HSA include deductibles which apply to all services covered by the plan (medical and prescription) and the HSA enrollee cannot have any other coverage that provides first-dollar coverage of medical expenses (dual coverage on spouse's plan) and cannot have a health care Flexible Spending Account (FSA) to pay for medical expenses.

Stipends offered to school employees and/or other agencies can be used to pay premiums of the plan but not used to pay down a deductible or copay. More information is needed on how the HSA would interact with these stipends for possible negotiations. Minimum deductible has to be met. A delta between funding and minimum out-of-pocket could have a seed equivalent to the deductible as shown in the illustrative scenarios on plan designs. Illustrative HSA rates shown are based on actuarial relativity to FY18 rate for CDH Gold with employee contributing 5% of the total premium. Per Delaware Code, the State must pay 95% of the premium for a consumer-directed health plan. The GHIP has flexibility in setting the HSA plan design (subject to IRS-qualified HDHP provisions) and budget rates to increase appeal relative to existing plan options. Additional illustrative scenarios were provided and reviewed. Advantages of the HSA for current employees and former employees, including COBRA participants and retirees were covered. Differences between the HSA versus HRA were examined. Demographic considerations reviewed as millennials are more likely to engage in consumerism behaviors targeted by HSA plans. New Jersey provides two HSA-qualified high deductible health plans alongside other traditional plan options, where other surrounding states do not. SBO is working on getting information on the enrollment in these plans within New Jersey. Other implementation considerations were portrayed. Pros and cons of moving the State's benefit plan year to a Calendar Year were presented. An illustrative implementation timeline was shown to maximize the success of the HSA allowing the State at least twelve months to implement. Discussion occurred of offering new plans in addition to this HSA plan if it moves forward and if this HSA plan can be built to be fully utilized and navigate employees to it. How these HSA funds are managed (through TPA's) and dispersed was briefly discussed and will revisit for later discussion.

WTW to provide the average cost to employees for the CDH Plan including amount employee is paying for premiums and deductible; then if employee moves to HSA-1 or HSA-2, this is what it will look like (for employee) and shows how it impacts that employee and shows the benefits. Future key decision points were presented. WTW shared topics for discussion at the June 25th SEBC meeting.

Other Business

The remaining two items on the agenda (5a and 5b) are moved to July's meeting.

Public Comments

Karol Powers-Case thanked the Committee for all their hard work and asked them to keep in mind that the deductible is twice what it would be and will be difficult for members to come up with.

Motions

Director Jackson asked for a motion to adjourn the meeting. Secretary Johnson made the motion and it was seconded by Treasurer Simpler. The motion carried unanimously. Meeting adjourned at 3:22 p.m.

Respectfully submitted,

Lisa Porter
Executive Secretary
Statewide Benefits Office, DHR